March 4, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0648-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ sustained injury to her neck and lower back on ___ when she was knocked down between two bread rack s at work. Her worst pain following this injury was located in her neck where she continued to have neck pain with numbness in both hands. She also complained of lower back pain. An MRI was done. It demonstrated a disc rupture in the C5/6 level for which conservative treatment failed to relieve symptoms. She underwent anterior cervical fusion with discectomy at the C5/6 level. ___ performed this procedure on November 30, 1999. She had no complications and was somewhat improved by the surgery. ___ released her to normal activities on April 26. 2000. She then changed doctors and began seeing ___, a chiropractor. She saw ___, an orthopedic surgeon, and an independent medical evaluation was done on July 30, 2002. ___ felt that she needed only supportive maintenance treatment for her back and neck. He did not feel that any further diagnostic testing was needed.

REQUESTED SERVICE

The patient's treating physician has requested EMG and nerve conduction studies.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

After review of the vast records provided, the reviewer finds no clinical information to support the need for these studies. There is no objective evidence of neurological findings that would support the need for this testing. The patient is being treated with medication and her imaging studies do not reveal any significant neural impingement. The records reflect no motor or sensory loss and no clinical signs of neurologic deficit that should be investigated with an EMG and nerve conduction study.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief

Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of March 2003.